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Mental health in the kingdom of God

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Abstract

Mental disorders are both common and disabling worldwide. They affect beliefs, emotions, identity and relationships in such a way as to impact upon the very essence of human experience. They are associated with stigma and prejudice, and they disproportionately affect those who are poor and those who belong to marginalized groups within society. Increasing attention has been given in recent years to the importance of spirituality for mental health, but in research it is impossible to distinguish between spirituality and the psychological variables that it purports to influence. Those things that are identified as being the concerns of mental health professionals overlap significantly with the concerns of religion. This overlap is examined here in relationship to the Synoptic Gospel accounts of the mission, ministry and teaching of Jesus. It is proposed that Jesus' teaching on the kingdom of God was centrally concerned with things that we now consider to be the domain of mental health. For Christians, mental health may be understood as the ability to fulfil vocation within the kingdom of God. A more critical theological understanding of mental health is needed to better inform the mission of the Church of England.

Keywords

kingdom of God, mental health, mission, spirituality, vocation

Does mental health matter within the kingdom of God? This article seeks briefly to explore the nature of the relationship between contemporary concerns about mental health and the mission, ministry and teaching of Jesus about the kingdom of God within the Synoptic Gospels.

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Mental health

Does mental health matter?

- Worldwide, common mental disorders affect one in five adults,¹ and major mental disorders affect somewhere between 1 and 7 per cent of adults.²
- Some 10 to 20 per cent of children and adolescents suffer from mental disorders³ and half of all mental illnesses begin by the age of 14.⁴
- Because mental disorders begin early in life and tend to be chronic, they represent the leading cause of disability worldwide. One-third of years lived with disability are due to mental illness.⁵
- Mental disorders also shorten lives. Life expectancy is reduced by 10–20 years for those suffering from major mental disorders.⁶

More important than the statistics are the nature and depth of the human suffering with which mental illnesses, or mental disorders, are associated. Behind the statistics are traumatized, hurting and disorientated people who have been torn apart inwardly and who are distanced socially from their families and communities.

The signs and symptoms of mental illness are many and diverse and they concern the very essence of our experience of what it is to be human. If we cannot trust the inner or outer voices that we hear, if we can no longer rely on our own ability to find meaning in what we experience, if we can no longer remember our own history, or rely on our own beliefs in what is true, if life is pervaded by anxiety or hopelessness, then it cuts to the core of our experience of ourselves and the world around us.

If we conceptualize these signs and symptoms, or group them according to the kinds of concerns that mental health professionals identify, then we can see that these are the same things that Christians and other religious people are also talking about, albeit perhaps in a slightly different language. They are our experiences of life at its deepest level – our beliefs, our capacity to find meaning, our ability to cope with adversity, our behaviour in relationship to others in the world around us, and so on. They are the very fabric of our self-understanding.

Mental health problems disproportionately affect those who are disadvantaged and marginalized in society – the poor, the homeless, prisoners, certain ethnic minority groups, gender and sexual minority groups, the deaf and other disabled people. Interestingly, there is also a vulnerability paradox. Wealthier countries, with more resources, experience a greater overall mental health burden than poorer countries. However, within each country or society, it is generally those who have the least who suffer the most.

Mental health problems are associated with stigma, bullying, prejudice and social exclusion. This is both cause and effect. So, for example, the experience of stigma for whatever reason confers a greater risk of mental disorders, but a diagnosis or social label of being mentally ill is in turn associated with yet more stigma.

All of this impacts upon every dimension of life. The World Health Organization (WHO) defines mental health not in terms of the absence of signs

or symptoms of mental illness but rather in terms of the capacity to cope with life, and to contribute fruitfully in work and in the wider community.⁷ The WHO does not specifically mention family – which is the context within which I believe the burden of mental disorders is often felt most acutely. It also overemphasizes work, which may not be realistic for all. However, it does at least define mental health in relationship. Mental well-being is experienced in community, not in isolation.

Psychiatry has emerged as the speciality within medicine devoted to caring for people with mental disorders. Psychiatry is an inter-professional and interdisciplinary endeavour and – for the present purposes – I use the term here to refer to the whole mental health team, including nurses, clinical psychologists, occupational therapists and others, as well as doctors. Psychiatry is concerned with both mind and brain, and the relationship between the two is still something of a mystery. Clinical care sometimes involves attention more to one than the other, but usually involves giving attention to both. At risk of oversimplifying, we might say that care for the mind involves talking therapies and attention to social circumstances, and that care for the brain involves physical treatments, particularly various kinds of psychotropic medication. Psychiatry – in both of these modes – seeks to be evidence-based and scientific. The good professional, however, does not allow this to devalue the things that are important but not easily measured, such as compassion, empathy, and a common humanity shared by clinician and patient alike.

Over the last four or five decades, research and clinical care have both given increasing attention to something understood by many as being at the heart of this common humanity: something commonly referred to as ‘spirituality’. Spirituality is difficult to define but is commonly concerned with things such as meaning and purpose in life, with the human being in relationship, and especially the relationship with a transcendent order, variously understood but for many simply meaning ‘God’.⁸ This has been controversial and has evoked considerable professional debate.⁹ Spirituality has proven difficult to measure – because it is subjective and not easily distinguished from the psychological variables that it purports to influence.¹⁰ People who are depressed, for example, commonly lose any sense of meaning and purpose in life and they view their relationships differently. They may feel rejected by God; but this is generally understood as the effect of depression, rather than its cause.

The difficulties encountered in distinguishing between spirituality and psychological well-being have led to an increasing research focus on religion – supposedly a more objective concept – measurable by such things as church attendance, religious affiliation or frequency of prayer, Bible reading or other religious practices. These, too, are prone to being confounded. The depressed person typically stops going to church, feels abandoned by God, and may abandon prayer. However, good clinical practice recognizes that culture – including religion – is an important part of understanding people in context. With increasing emphasis on person-centred care, this matters in clinical practice whatever the research complexities of distinguishing cause and effect. To some extent, these trends have reversed a long-held historical antipathy between psychiatry and religion, dating back to Freud. Nonetheless, there

is still often a gap between mental health professionals (more likely to be agnostic or atheist) and patients (more likely to be religious).

The outcome of all of this has been a somewhat reluctant and variable addition of spirituality to the biopsychosocial model that has dominated psychiatry for the last century or more. Spirituality (whether religious or not) has become a fourth dimension of clinical concern, alongside the psychological, social and biological. Around 3,000 members of the Royal College of Psychiatrists belong to its Spirituality and Psychiatry Special Interest Group. This makes it one of the larger special interest groups in the College, but it also leaves around 15,000 College members who presumably do not consider it a matter of special interest.

Good news

All of this may seem far removed from the central concerns of the Christian religion. Indeed, I suspect that, for many, the two are completely different matters. Just as you need to spend time in hospital recovering from your operation before you can return to church on Sunday, so psychological and pharmacological treatments will take time to get you better from your mental illness. Once they have taken effect, then you may be expected to return to church and to the practice of your faith. Medicine and religion each have their own, non-overlapping, domains of concern. Medical professionals help you with one; clergy and chaplains help you with the other.

But, given what I have said about the subjective experience of mental ill health, and given what I have said about the impossibility in research of separating spirituality from the things that psychologists measure, can this really be so? How does it look from the other side of the fence that has been erected between spiritual and mental well-being? Specifically, as Christians, what do we find that the Gospels have to tell us about mental health?

At the outset of his Galilean ministry, Luke¹¹ tells us that Jesus read in the synagogue a passage from the writings of the prophet Isaiah, which he took to summarize his mission. Jesus had good news for the poor, for those finding themselves held captive, for those living with disability, and for those struggling with oppression. These are exactly the issues with which people suffering from mental illness struggle today. First-century Palestine may have had some very different understandings of the nature of mental health compared with our day. We can be in little doubt, however, that in our day Jesus would see mental health as a priority within the context of his mission.

At the heart of Jesus' teaching was the kingdom of God. He taught in parables, using metaphors and vivid visual images. The kingdom is like yeast that leavens bread; it is a priceless treasure – like a precious pearl; it is a seed that grows into a great tree; a net that catches many fish; it belongs to the poor and to children.

Jesus' miracles – not least the stories of healings – were demonstrations of the coming of this kingdom. We are told that he healed many people of many different conditions, but the only story that specifically sounds like a healing of mental

illness in today's terms was that of the Gerasene demoniac.¹² Presenting with primarily behavioural symptoms, difficult to restrain, howling and self-harming, the man is restored by Jesus to 'his right mind'. In today's diagnostic terms, perhaps this man was suffering from mania, usually associated with bipolar disorder.

When we turn to the detail of Jesus' teaching – for example in the Sermon on the Mount – we discover that he was concerned with exactly the same things that we label as mental health issues. Take anxiety, for example. Along with depression, anxiety is a key symptom of the common mental disorders that affect around one in five people in our society. Unfortunately, Jesus' teachings, taken up later by Paul, are often misinterpreted in such a way as to make Christians feel guilty about their anxiety.¹³ I don't have space to explore this misunderstanding in detail here, but a more critical reading of the texts in question might suggest that this was not what Jesus or Paul intended.¹⁴ Jesus agonized with his impending fate in Gethsemane. Paul talked about his daily anxiety on behalf of the churches. Neither of them sailed through life in a stoic haze of passionless apathy. Rather, they both knew what their true priorities were. Within this ordering of the things that really matter in life they contextualized their worries and turned them into prayer. Life in the kingdom of God is not a life without anxiety; that would simply mean that we cared about nothing and no one. In the kingdom it is what we worry about, and what we do with our anxieties, that really matters.

Let's take another example from the Sermon on the Mount. Jesus warns about the distinction between religious practice that is oriented outwardly, towards what others think, and religious practice that is inwardly, and Godwardly, oriented.¹⁵ In a scientific paper by Gordon Allport and Michael Ross, originally published in 1967 and widely cited since, a very similar distinction was made between, respectively, extrinsic and intrinsic religiosity.¹⁶ A huge body of research since then has confirmed that intrinsic, but not extrinsic, religiosity is good for mental well-being. Human beings flourish in relationship with God; we do not do well when our religious practices are overly directed towards what others think of us.

At the heart of the Sermon on the Mount is Jesus' teaching on prayer, notably his teaching of the prayer that we know as the Lord's Prayer.¹⁷ As with his teaching on anxiety and outward religious practice, this all comes down to an ordering of priorities. Christians are called to put God's kingdom before everything, even before their daily needs for basic necessities such as food. Scientific research on prayer – such as it is – tends to suggest that prayer is good for us. It fails, however, to recognize this important ordering of priorities. We don't pray for the same reasons that we take an antidepressant. We pray because we want God's kingdom to come, his will to be done.

Jesus had some interesting things to say about forgiveness.¹⁸ Forgiveness, it turns out, is also good for human well-being. So-called 'forgiveness therapy' is beneficial in a wide range of mental health conditions.¹⁹ It typically does not consider the important Christian belief that we all have to be forgiven by God; it is, however, concerned with interpersonal forgiveness between human beings. 'Forgive us our sins, as we forgive those who sin against us ...'

I could go on ...

I hope that this whistle-stop tour through just a few highlights of the Sermon on the Mount will be enough to persuade you that I have a case. Jesus was concerned with exactly the same things that we are concerned with when we talk about mental health and well-being. He had a different sense of priorities, and he saw things through first-century eyes rather than as a twenty-first-century scientist, but mental health issues did feature prominently in his teaching.

What, then, does all this have to teach us about the nature of mental health?

I would like to suggest that – from a Christian perspective – mental health is about our capacity to fulfil our vocations, individually and collectively, within the kingdom of God.

It is not so much about the functioning of our brains and minds – although these do play a part – as it is about our ability to envision our place in the picture of the kingdom that Jesus paints. It is about our ability to find our place in the narrative of the kingdom, and to tell that story.

When I talk about the ‘ability’ to envision our place in the kingdom, or our ‘ability’ to tell our stories, I do not mean something concerned with cognitive capacities as much as something concerned with relationships to God and the world around us. This ‘something’ is neither completely un-reliant on the functioning of our brains and minds nor is it coterminous with them. It is rather a function of the physical, spiritual and psychosomatic unity of what it means to be a human being in God’s world. Perhaps some people with mental health diagnoses are doing rather better at this than some folks who don’t have such a diagnosis.

This fulfilling of our Christian vocation will not be easy! Don’t forget that Jesus calls us to find our lives in losing them.²⁰ He calls us to take up our cross and follow him.²¹ Paul understands his vocation as a sharing in Christ’s suffering²² – and Christ suffers horribly in Gethsemane and on Calvary. The gospel is not an easy way out; it does not promise a stress-free life in which all anxiety and mental suffering are banished. It does, however, offer a realistic account of the world in which we live. More importantly, the incarnation of God in Christ shows us that we are not alone. In Christ, God shares in the kinds of suffering that we call mental illnesses. Mental illness is not a failure of Christian faith; it is a challenge to Christian faithfulness.

Faith and mental health: a Christian response

Going back to the beginning, then, does any of this have any impact on the way in which we view mental health issues within Church and society? I believe that it does. More than that, I believe that it radically challenges our misunderstandings of the nature of the relationship between faith and mental health. Among these misunderstandings, we might consider three, briefly, before I conclude.

First, I think that there is a pervasive misunderstanding of the nature of mental health which concerns the relationship between science and religion, or science and theology. We tend to think of the mental health sciences as telling us about how

brain and mind function, and the great religious traditions as telling us about what it all means. Perhaps, to an extent, there is some truth in this, but this distinction elides the extent to which they are talking about exactly the same things – the things that worry us, the ways in which we cope with adversity, the people and things that we love and desire most deeply. We cannot separate out the two conversations as though science and religion were talking about completely different things. They are both talking – at least in relation to mental health – about the very essence of the human condition. They may use different language to do this, but, if that is so, we need to get better at translation.

Second, there is much misunderstanding in each domain about how best to deal with the concerns of the other. By way of example of the progress that we are making in this respect, I would like to mention here two policy documents of the Royal College of Psychiatrists that have helped the situation a little in recent years. In one, we find recommendations for psychiatrists on how to deal with spirituality and religion in clinical practice.²³ In the other, we see spirituality and religion identified as one of the diverse ways in which we need to place patients' concerns firmly at the centre of good practice and professional training.²⁴ These developments – especially the former – have not been uncontroversial and there is still a need for more progress and greater mutual respect.

Do we have similar policies within the Church of England? It would seem not, and I wonder why we don't. Clergy need guidance on how to deal with mental health issues in their congregations, just as much as psychiatrists need guidance on how to deal with spiritual and religious concerns raised by their patients.

The third misunderstanding – one in which we have all colluded to a greater or lesser extent – is that matters of faith, including Christian faith, exist within some kind of bubble that is almost completely separate from the realities of mental illness. Things within the bubble – spiritual and religious things – are primarily the concern of well people. If you are not well, then you need mental health professionals to help get you well, so that you can go back to paying attention to whatever is in your bubble. While you are ill, mental health chaplains do have a part to play, but this is not often thought of as being central to the work of the mental health team. It is optional, infrequently taken up, and often completely disconnected from the work of the clinical team.

I would like to think that – somehow – we can burst the bubble and reintegrate faith with the fabric of mental healthcare. For me, as a Christian, this is all about understanding mental health within the context of the kingdom, and understanding the kingdom within the context of mental health and well-being.

The Church also has its own bubble, within which mental health is seen as a minority concern, peripheral to the real mission of the Church. Within this view of things, mental health is viewed primarily as the concern of the health service. Mental health is not specifically mentioned anywhere within the objectives of the Archbishops' Council of the Church of England. It is dispersed across at least six different parts of the structures of Church House. As far as the Church of England is concerned, it is everyone's business and no one's business.

I am a psychiatrist as well as a priest, and so my reading of the Gospels is unlikely to be representative of the wider Church. However, I cannot read the Synoptic Gospels without seeing mental health as central to Jesus' mission and integral to the way in which the Evangelists understood him to have taught about the kingdom of God.

I would like to see our bubble burst. Mental health should be seen as central to the mission of the Church. Human beings are not put together like Lego, with bodies, minds and souls each representing different coloured bricks. We are an integral spiritual and psychosomatic unity created for relationship with God. The Church needs to have a vision of its mission that reflects this.

Notes

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